

45th 2/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445479	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LIFE CARE CENTER OF G B. WING _____		(X3) DATE SURVEY COMPLETED  01/04/2012
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF GRAY			STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615		
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K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.)</p> <p>The findings include:</p> <p>Observation and interview with the Maintenance Director, on January 4, 2012 at 10:40 a.m. confirmed corridor door to resident room 406 failed to close to a positive latch and the fire door near Station 1 nurses Station failed to close when the fire alarm was activated.</p>	K 021	<p>A. What corrective actions will be taken to correct this alleged deficient practice? No residents were affected.</p> <p>B. Identify residents that have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected.</p> <p>C. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practices does not recur: New magnetic door holders ordered for fire door for station 1 nurses station on 1/9/12. Corridor door to resident room 406 immediately fixed to positive latch on 1/4/12 by maintenance director. Drill will be conducted once weekly for three months to assure these doors close to a positive latch.</p> <p>D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place. The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100 % compliance is achieved.</p>	02/17/12	
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at</p>	K 025	<p>A. What corrective actions will be taken to correct this alleged deficient practice?: No residents were affected.</p> <p>B. Identify residents that have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected.</p>	02/17/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD Is not met as evidenced by: Based upon observation and interview, the facility failed to assure building fire barrier construction was maintained.  The Findings include:  Observation and interview with the Maintenance Director, on January 4, 2012 at 11:30 a.m. confirmed the 4-hour wall at station 4 had multiple unsealed penetrations. Observation and interview with the Maintenance Director, on January 4, 2012 at 11:50 a.m. confirmed the fire wall and fire-rated ceiling by the mechanical room near room 115 was damaged and not sealed with a firestop system.	K 025	C. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practices does not recur: Re-educate maintenance staff on the importance of ensuring penetrations are filled immediately on 1/4/12 by the nursing home administrator. The penetrations in the 4 hour wall at station 4 were filled on 1/14/12. The penetrations in the firewall and fire rated ceiling by mechanical room near room 115 were filled on 1/14/12. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place. The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029	A. What corrective actions will be taken to correct this alleged deficient practice? No residents were affected. B. Identify residents that have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected.		02/17/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029	Continued From page 2 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include:  Observation and interview with the Maintenance Director, on January 3 at 10:15 a.m. confirmed the mechanical room by room 111, Medical records storage room doors in Station 2 and 3 were not provided with door closers (NFPA 101, 19.3.2.1 (7)).	K 029	C. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practices does not recur: Door closure ordered for Medical Records office on 1/20/12. Will be installed immediately upon arrival. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place. The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by:	K 050	A. What corrective actions will be taken to correct this alleged deficient practice? No residents were affected.  B. Identify residents that have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. C. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practices does not recur: All staff in-serviced on proper fire drill procedures. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place.	02/17/12	

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K 050	Continued From page 3 Based on observation and interview, the facility failed to assure staff was familiar with fire drills procedures. The findings include: Observation during a fire drill conducted on January 4, 2012 at 10:20 p.m. confirmed the person discovering the fire failed to call out the required code phrase and location.	K 050	The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure GFCI outlets were located in all wet areas (NFPA 70, 517-20). The findings include: Observation and interview with the Maintenance Director, on January 4, 2012 at 9:00 a.m. confirmed GFCI protection was not provided at the Station 3 medication room that had a refrigerator plugged into a power strip next to a sink. Based on observation and interview, the facility failed to assure electrical devices were protected from contact. The findings include: Observation and interview with the Maintenance Director, on January 4, 2012 at 2:15 p.m. confirmed a 120 volt thermostat in the attic above the access by room 117 was not provided with a cover.	K 147	<p>A. What corrective actions will be taken to correct this alleged deficient practice? No residents were affected.</p> <p>B. Identify residents that have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected:</p> <p>C. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practices does not recur: Re-education with maintenance staff on assuring GFCI outlets are located in all wet areas and 120 volt thermostats should have a cover on 1/4/12 by Nursing Home Administrator. GFCI outlet installed at Station 3 medication room and cover put on thermostat in attic by room 117 on 1/4/12. Will do audit of GFCI outlets once a week for three months. Will also audit covers on thermostats once a week for three months. Maintenance director or ED to monitor.</p> <p>D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place. The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.</p>		02/17/12